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Qualifications, Roles, Advanced Competencies, and Job Descriptions for Physical Therapy Services in the Public School/Educational Setting

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QUALIFICATIONS, ROLES, ADVANCED COMPETENCIES, AND JOB DESCRIPTIONS FOR PHYSICAL THERAPY SERVICES IN THE PUBLIC SCHOOL/EDUCATIONAL SETTING

by

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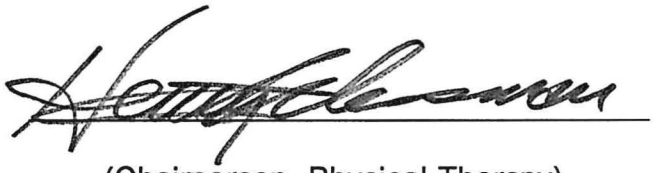
This Independent Study, submitted by Anne G. Putbrese in partial fulfillment of the requirements for the Degree of Master of Physical Therapy from the University of North Dakota, has been read by the Chairperson of Physical Therapy under whom the work has been done and is hereby approved.



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ABSTRACT

The North Dakota Physical Therapy Association, the state professional organization for physical therapy practice, asked several of its members involved in the area of pediatric practice to develop guidelines for physical therapy practice in the public school setting in North Dakota. Eleven physical therapists met to give input on developing these guidelines. A list of topics to include in the guidelines was generated, and several therapists volunteered to research and develop one or several of the topics on the list. This independent study report developed information on the topics of qualifications, roles, advanced competencies, and job descriptions for physical therapy service in the public school/educational setting. In researching these topics, the author reviewed North Dakota state physical therapy licensure law and its accompanying rules and regulations; federal legislation related to practice in the public school setting; guidelines developed by other states and individual special education districts; physical therapy professional standards and policy statements developed by the national physical therapy professional organization; and journal articles and books written about these topics.

The independent study report describes qualifications, role descriptions, competencies, and specialization processes for the physical therapist; qualifications and role descriptions for the physical therapist assistant; and a

brief statement on roles and qualifications of the classroom aide. Also included in this report is information on what should be included in a job description and different uses for job descriptions. It is the intent of the final published guidelines for physical therapy practice in the educational setting in North Dakota to assist personnel involved to provide high quality, yet cost effective, physical therapy services.

CHAPTER I

INTRODUCTION

In 1989, the Quality Assurance Committee of the North Dakota Physical Therapy Association (NDPTA) asked the North Dakota representative to the Section on Pediatrics of the American Physical Therapy Association (APTA) to assist in developing guidelines for physical therapy practice in the public school setting. In October, 1990, the Section on Pediatrics representative met with the North Dakota school physical therapist state liaison to the APTA to share ideas on how to develop these guidelines. These physical therapists developed the following plan of action:

1) gather resources from several surrounding states on what they have for guidelines and review these guidelines
2) contact the North Dakota State Department of Education to obtain any guidelines they might be using in regards to physical therapy services
3) identify physical therapists in North Dakota who might be interested in assisting with or giving input to developing these guidelines.

In September, 1991, eleven physical therapists met in Grand Forks, North Dakota, to give their input on developing public school guidelines. The information gathered by the Section on Pediatrics representative and the school

physical therapist state liaison was available for the group to review. Those present at this meeting agreed that developing guidelines would be beneficial for physical therapists, educational administrators, educators, families, and the child eligible for or receiving physical therapy services. The group then generated a list of possible topics to include in these guidelines.

Several of the physical therapists in the group were enrolled in the 1991-1993 University of North Dakota out-of-house clinical master of physical therapy program, and some indicated an interest in researching and developing certain aspects of the guidelines for an independent study requirement for the masters program. The entire group plans to meet again at the April, 1993, North Dakota Physical Therapy Association (NDPTA) meeting. This author chose to research roles, qualifications, job descriptions, competencies, and specialization for physical therapy practice in the public school/educational setting. After completion of this independent study, this author plans to condense the information (after consulting with other physical therapists involved in developing the guidelines) to use in published guidelines for physical therapy practice in the educational setting in North Dakota.

CHAPTER II

METHODOLOGY

In 1990, the American Physical Therapy Association (APTA) and its Section on Pediatrics published Physical Therapy Practice in the Educational Environments--Policies and Guidelines.[1] This document was generically designed to help schools provide physical therapy services and also to provide APTA members with guidelines to establish relations with schools and agencies moving toward implementation of federal legislation (PL 94-142[2] and PL 99-457[3]). Included in this document are sections on role definitions, qualifications and requirements of PTs, use of physical therapist assistants, professional standards, and competencies.

North Dakota presently does not have official state guidelines regarding physical therapy practice in the schools. Many other states have already developed guidelines. These documents, especially from rural states, were reviewed. Totline (1987-1988) and Pediatric Physical Therapy are the official publications of the Section on Pediatrics of the APTA. The journal is published quarterly and contains many features that will be reviewed in writing these guidelines. The Section on Pediatrics has a Practice Committee, and one area this committee addresses is pediatric physical therapy practice in the educational setting. This committee's opinions are published in the journal.

This journal has published a list of states that have developed their own guidelines. The journal contains book and article reviews in each volume which were scanned to find additional references on this topic. The journal has advertisements for new publications that pertain to this topic. Many articles published in this journal have been written about physical therapy practice in the school setting. The Section on Pediatrics is involved in keeping current on legislation affecting practice in the educational setting. Updates published on legislative issues were reviewed.

Several individual special education districts in North Dakota and northern Minnesota have developed guidelines or information booklets on provision of educationally-related services. (Physical therapy is considered a related service). These publications were reviewed.

Some aspects of the North Dakota state licensure law and rules and regulations regarding the practice of physical therapy will be important to include in any proposed guidelines. Education administrators need to know requirements and qualifications necessary to obtain and maintain a license to practice physical therapy in North Dakota. The sections of the law governing the practice of physical therapy that may be pertinent to practice in the educational environment were reviewed.

The APTA has adopted several policy statements important to practice in the school setting. These include "Physical Therapy Practice in Educational Environments"[1(p1.2)] and "Definition and Utilization of the Physical Therapist

Assistant."[1(p8.2)] These two documents were considered when writing North Dakota guidelines regarding roles and job descriptions.

Physical therapy professional standards were considered when writing the guidelines as the education profession is not familiar with these standards as they relate to the therapist's role in the educational setting. These standards include APTA Standards of Practice,[1(pp9.2-9.3)] the APTA Code of Ethics,[1(p9.4)] and the Guide for Professional Conduct.[1(pp9.4-9.6)]

In 1976, the House of Delegates of the APTA approved the concept of specialization in physical therapy. One recognized specialty area is pediatrics. Specialty certification in pediatrics is now available. The book Specialty Competencies in Physical Therapy: Pediatrics[4] was published in 1985 by the Board for Certification of Advanced Clinical Competence, Pediatric Specialty Council. Although certification is not necessary to practice pediatric physical therapy, it would be beneficial for education administrators to know this process is available for recognition of advanced level of competency in pediatrics. The APTA Education Department has developed a series called In Touch[5] which is a home-study continuing education course. One of these series covers pediatric topics. The APTA Section on Pediatrics has developed several competency documents for different areas of pediatric practice. These include "Competencies for Physical Therapists in Early Intervention." (Appendix A) With federal legislation PL 99-457,[3] school system physical therapists will require competencies in dealing with neonates and early intervention.

Other specialization and certification processes related to pediatric practice, such as Neurodevelopmental Treatment Certification and Sensory Integration will be described.

CHAPTER III

PERSONNEL

Physical Therapist

Qualifications

The practice of physical therapy in the state of North Dakota is governed by the North Dakota Physical Therapy Practice Act, North Dakota Century Code Chapter 43-26,[6] and Administrative Rules Title 61.5.[7] The Practice Act states that an individual must be registered in order to practice physical therapy in North Dakota. To qualify for registration, the individual must be at last 18 years old, be of good moral character, and have graduated from a school of physical therapy approved by the North Dakota State Examining Committee for Physical Therapists (the committee that administers Chapter 43-26).[6] An individual can be registered if they meet the above requirements and if they pass an examination in physical therapy. Registration must be renewed annually by paying a fee and providing proof of continuing education. All physical therapists must obtain 25 contact hours of continuing education every two years to be eligible for reregistration.

The administrative rules[7] define "school of physical therapy" as a curriculum approved by the American Physical Therapy Association. "Examination" is defined as the examination adopted by the American Physical

Therapy Association or the Federation of State Boards of Physical Therapy. In North Dakota, 1.5 standard deviations below the national mean is the lowest score that can be achieved to pass the exam. An applicant for registration who is currently licensed in another state and has passed the exam by North Dakota standards will not have to retake the exam unless they have not practiced physical therapy for five years or more.

The administrative rules also have a specific section on registration requirements for foreign-educated physical therapists.[7] The applicant must have documentation verifying graduation from a physical therapy program which is approved in the country in which the applicant received the education. The applicant must have evidence that the PT program attended had educational requirements comparable to programs approved by the American Physical Therapy Association. The applicant must also provide a letter from a registered, practicing physical therapist in North Dakota stating that the applicant will work under that physical therapist's direct supervision for six months (the applicant may be excused from this last requirement if they have at least six months working experience in physical therapy in the United States).[7]

Other resources have listed qualifications that are recommended but not required for the unique practice of physical therapy in educational setting. In "Physical Therapy Practice in Educational Environments,"[1] qualifications recommended to ensure quality physical therapy care include:

1) knowledge of the state special education rules and regulations

2) knowledge of pediatric conditions and pediatric physical therapy

3) experience in school physical therapy

4) continuing education in the field of special education or related to physical therapy practice in educational environments

Iowa guidelines[8] state that therapists employed in educational settings need special training or background in general human and behavioral development, neuromotor development and treatment techniques, the design and use of adaptive equipment, parent-team-teacher training techniques, rules and regulations of special education, and writing IEPs. In Moorhead, Minnesota,[20] required qualifications include the ability to evaluate, instruct, and educate; effective communication skills; and the ability to supervise and motivate others. These qualifications are not unique to practice in the educational setting, but are very important in this setting where the physical therapist must work together with parents, educators, support staff, and the child. In Moorhead, previous pediatric experience is recommended but not required.

One article reviewed[9] discusses a model curriculum at the University of North Carolina designed for graduate pediatric physical therapy students to prepare them for an expanded role as a practicing physical therapist in the public school setting. The goal of the information provided in the graduate course was to prepare therapists with qualifications to be: 1) knowledgeable about public education and its implications for disabled students; 2) able to plan

and organize physical therapy programs while considering the role of other professionals in public schools; and 3) able to consult with, train, and supervise school personnel in physical therapy management techniques so the child may benefit from their educational program.

The Program in Pediatric Physical Therapy, Hahnemann University (Philadelphia Pennsylvania, April 1987)[1(pp4.1-4.5)] also developed five major competencies headings for school physical therapists. These are:

1) knowledge of the role of the physical therapist in the school system as defined by laws, rules, and regulations affecting the district served by the therapist
2) the ability to evaluate the student's functional capabilities and limitations pertaining to the student's education level and needs.
3) the ability to design, implement, and evaluate a physical therapy education program that will have an impact on the student's educational program
4) having the skills to function as a consultant, educator, supervisor, and resource person.
5) the ability to plan, implement, and evaluate the administrative aspects of physical therapy service in the educational setting

The authors indicate that consultant, educator, supervisor, resource person, and administrator may be beyond the responsibilities of some therapists.

Role of the Physical Therapist

A physical therapist's role, in general, is dictated by state law and the American Physical Therapy Association's standards, guidelines, and Code of Ethics. The role of the physical therapist in the educational setting is also dictated by these measures, but, in addition, includes Federal Legislation on Special Education and APTA Section on Pediatric Policies and Guidelines. This chapter will review the role of the physical therapist as described in North Dakota Physical Therapy Practice Act; APTA standards, guidelines, and Code of Ethics; and the APTA Section on Pediatrics Policies and Guidelines. This chapter will then review different approaches to describing the role of the physical therapist in the educational setting--approaches developed in states other than North Dakota, and approaches developed by groups or individuals involved with PT services in the school environment.

In 1986, the APTA Board of Directors adopted a model definition of physical therapy:[1(p3.1)] "Physical therapy is defined as the examination, treatment, and instruction of human beings to detect, assess, prevent, correct, alleviate, and limit physical disability; movement dysfunction; bodily malfunction; and pain from injury, disease, and any other bodily and mental conditions. Physical therapy includes the administration, interpretation, and evaluation of tests and measurements of bodily functions and structure; the planning, administration, evaluation, and modification of treatment and instruction, including the use of physical measures, activities, and devices for preventive

and therapeutic purposes; and the provision of consultative, educational, and other advisory service for the purpose of reducing the incidence and severity of physical disability, movement dysfunction, bodily malfunction, and pain."

The APTA Code of Ethics[1(p9.4)] addresses the role of the physical therapist by stating that there are certain responsibilities and roles which cannot be delegated to others. These include establishing channels of written and oral communication; interpreting information about an individual under care; providing an initial evaluation; developing a treatment plan including short- and long-term goals; selecting and delegating tasks of treatment plan; assessing abilities of support personnel to perform delegated tasks; directing and supervising supportive personnel in assigned tasks; identifying and documenting precautions; contraindications, goals, anticipated progress, and re-evaluation plans; performing re-evaluation, adjustment of treatment plan, performing final evaluation, and followup plan.[1(p9.4)]

In the North Dakota Century Code,[6(43-26-01)] physical therapy is defined as "the art and science of a health specialty concerned with the prevention of disability and the physical rehabilitation for congenital or acquired disabilities resulting from, or secondary to, injury or disease." The practice of physical therapy includes[6] evaluation, treatment, planning, instruction, and consultative services. Direct treatment includes "therapeutic exercise, neurodevelopmental procedure, therapeutic massage, mechanical devices, and therapeutic agents which employ the physical, chemical, and other properties of air, water, heat,

cold, electricity, sound, and radiant energy for the purpose of correcting or alleviating any physical or mental condition or preventing the development of any physical or mental disability."[6(43-26-01)] The North Dakota Century Code draws from APTA guidelines in providing role definitions for the practice of physical therapy in the State of North Dakota.

When investigating the role of the physical therapist in a specialized setting, such as the educational setting, there are a number of sources from which to draw information. One of these sources, the APTA Section on Pediatrics Policies and Guidelines,[1] states that the scope of physical therapy services in the educational environment is directed toward allowing a student with a dysfunction to participate in and benefit from the appropriate educational program. Tada and Harris[13] have differentiated between the role of the physical therapist in an educational setting and the role of the physical therapist in a typical medical setting. In the medical setting, therapy is provided one-to-one, and therapists try to determine the underlying cause of problems. In the educational setting, physical therapists may instruct teachers and classroom aides in performing physical therapy activities, which may be compensatory strategies rather than remediating the underlying disorder.

Harris[14] has described the role of the physical therapist as it relates to Public Law 99-457,[3] also known as the Education of the Handicapped Act Amendment of 1986. Family involvement is the primary theme of Part H of Public Law 99-457 and includes the important component of case management

services. Case management services "are designed to enable families of handicapped infants and toddlers to gain access to needed services in a timely manner."[14(p2)] Case management also coordinates needed services. This law provides that physical therapists not only provide primary services, but that they also may have the role of case managers. As case managers, physical therapists in North Dakota will need to be knowledgeable about the activities occurring in North Dakota that pertain to Public Law 99-457.

Information on role definitions for physical therapists was obtained for this review from a number of representative states. Personnel at Oregon Health Sciences University have written a comprehensive manual[15] specifically describing the role of the physical and occupational therapist in the educational setting. In this manual, the stated primary role of the therapist is to provide services that will assist students to benefit from their educational program. A general statement is given on the services provided by physical therapists and physical therapist assistants. These services "promote improved quality of movement and posture; gross motor balance, strength, and coordination; functional posture; appropriate positioning; and mobility. They recommend, construct, and teach others to use and maintain adaptive equipment, such as wheelchairs, prone boards, and other devices used for positioning and mobility."[15(p5)]

This manual[15] also describes the roles of the members of the multidisciplinary team in the educational environment. The goal of the

multidisciplinary team is to develop an Individual Education Plan (IEP), which is a systematic way to address the needs of the child with a disability. In order to achieve this goal, each team member, including the physical therapist, must keep in mind the following team roles:

1. Focusing team efforts on addressing the needs of students by integrating assessment information and developing IEP goals based on input from all pertinent disciplines.
2. Meeting periodically, whether formally or informally, to exchange information and keep one another abreast of changes in the student's program.
3. Demonstrating a high level of competence in one's own discipline so that contributions are valuable.
4. Demonstrating respect for the contribution from the other disciplines by actively seeking ways to incorporate their assessment data and recommendations into the IEP.
5. Consciously and continually working to educate one another in one's own discipline by welcoming questions, explaining terms and concepts in everyday language, and avoiding discipline-bound jargon.

The Oregon manual[15] identifies eleven functional areas of therapeutic intervention and describes the role the physical therapist plays in each functional area. In the area of self-help, physical therapy deals with mobility

and transfer skills, adaptive equipment, wheelchairs, splints, braces, and artificial limbs. In the area of functional mobility, services include equilibrium and balance reactions, transfer skills, and gait and pre-gait evaluation and training with or without ambulation aids. In the area of environmental adaptations, the physical therapist may recommend modifications of the school's or student's equipment or removal of architectural barriers.. In the area of positioning, physical therapists address positioning with adaptive devices, handling methods, range of motion, skin care, splints, and braces. In the area of neuromuscular and musculoskeletal systems, the physical therapist may evaluate and treat muscle strength, endurance, range of motion, gross and fine motor coordination, motor planning, oral-motor control, control of muscle tone, integration of developmentally appropriate reflexes and reactions as the basis for more normal movement, and musculoskeletal deformities and deviations. In the area of sensory processing, physical therapy addresses equilibrium and protective reactions; muscle tone; integration of touch; visual, auditory, proprioceptive, and kinesthetic input; motor planning; and coordination of the two sides of the body. In the adaptive equipment area, physical therapists evaluate, recommend, and construct positioning devices and modify existing devices. The fine motor area's services are provided by the occupational therapist. In the area of communication, physical therapists evaluate and recommend appropriate positioning of students, and, in coordination with speech therapists, evaluate and recommend adaptive

equipment and communication devices necessary for functional communication. In the area of prevocational and vocational skills, the physical therapist looks at general strength, sitting and standing balance and tolerance, motor coordination, and adaptive equipment. Finally, in the area of physiological function, physical therapy addresses cardiorespiratory function and fitness, muscular training, body mechanics, and energy conservation techniques.

A brochure developed by the physical therapists of the Pediatric Special Interest Group of Maryland and funded by the APTA Section on Pediatrics[16] divides the roles of the physical therapist in the educational environment into services they provide to the different groups encountered in the school setting. These groups include the special needs student, the educational staff, the administration, and the parent. Roles involving the special needs student include screening and assessment, direct and consultative services, and providing a communication network for a more effective learning environment. Roles involving the educational staff and other team members include input to IEP, individual programming for students, establishment of coordinated physical management plans, and consultation and inservice training. Roles involving the administrator include coordinating an effective service delivery model; providing information on the educational implications of handicapping conditions; documenting the need for related services; assisting in budgeting, planning, and purchasing of equipment; program advocacy; consulting on environmental design and modification; being a liaison with medical caregivers; consulting on

development of Individual Family Service Plans, and assisting with transition plans to a new school environment. The service provided the parent includes consultation, input for development of IFSP, case management, and advocacy strategies.[16]

The state of Washington[17] developed the following role description of a physical therapist in the public school setting. This description is very similar to the APTA's model description.

> The school physical therapist is a licensed health care professional with Educational Staff Associate certification who provides services for children with identified physical disability, motor deficit, movement dysfunction, and/or developmental delay which interfere with learning. Physical therapy services seek to prevent or minimize disability, relieve pain, develop and improve sensory and motor function, control postural deviations, and maintain or attain optimal performance within the individual's capabilities in the educational environment.[17(p96)]

Washington identifies the following services provided by the physical therapist: screening; evaluation and assessment; program planning for the IEP; treatment/management of disability; consultation and education; administration of physical therapy service; and research and evaluation of physical therapy services.

In North Carolina's plan[18] for physical therapy services in schools, the services provided are divided into three major areas: direct student-related services, indirect student-related services, and programmatic services. Direct student-related services include screening, evaluation, IEP development, and direct therapy. Indirect student-related services include management, monitoring, and consultation. Management programs are intervention techniques developed, taught, and supervised by the physical therapist, but administered by another person. Monitoring involves periodic checks by the PT with at-risk pupils who presently are functioning optimally at home and school. The purpose of monitoring is early detection of deterioration and identification of problems that may occur as the student develops. Consultation involves specific instruction by the physical therapist regarding the student's program and physical management in school or at home. Programmatic services facilitate effective integration into the educational environment. These services may include the following areas:[18]

1. Offer recommendations for student placement and special classroom equipment or personnel needs.
2. Communicate and plan with engineering services and principals regarding accessibility modifications.
3. Provide recommendations to transportation services and principals regarding vehicle modifications and training programs for drivers.
4. Consult with physical education administrators.

5. Promote acceptance of disabled students.
6. Conduct or assist with workshops and inservices regarding disabilities and implications for education.
7. Maintain appropriate records and statistics for federal/state reports and program growth.
8. Budget for special equipment or materials and train education personnel in their safe use.
9. Work with parent groups to establish a cooperative relationship between home and school.
10. Coordinate with preschool handicapped programs to develop strategies for transition into public school programs.
11. Build relationships with community agencies and civic groups for sharing resources and skills.
12. Develop procedures for emergency evacuation with attention to the special needs of the physically disabled.

Iowa's guidelines[8] include a very short section on the role of the physical therapist in the educational setting. Roles listed in this section include identifying the pupil's disability, pointing out the pupil's strengths in relation to current educational needs, providing direct physical therapy to improve motor development or motor performance as it relates to the educational performance of the student, and communicating with medical personnel if the pupil is receiving therapy in both the medical and educational setting. The main

purpose of physical therapy services is to enhance student performance and assist the educational process. Iowa's guidelines[8] assume that the students have access to both occupational and physical therapy services and then divide responsibilities for areas of assessment. Occupational therapists are responsible for activities of daily living, feeding, and manipulation skills. Physical therapists are responsible for the areas of positioning (independent sitting, standing, etc.; assisted alternative positions; transportation), and mobility (mobility/motor skills, ability to handle architectural barriers, using appropriate assistive devices, and transfers).

Individual special education districts sometimes develop their own guidelines for PT services. The Upper Valley Special Education District of North Dakota developed PT and OT guidelines,[19] including specific roles for each discipline. The physical therapist's roles are divided into four major categories. The first category is developing prerequisites for gross motor skill development which includes the areas of automatic balance responses, trunk control for upright postures, more normal movement patterns in legs and feet, and full range of motion in trunk, legs, and feet. (Arms and hands are included in the role for occupational therapists.) The next category is developing mobility which includes development of independent walking, crawling and creeping; use of wheelchairs; use of assistive devices, such as crutches, canes, walkers, and adaptive tricycles; and use of prosthetic devices. The third category is recommending equipment and training a student to use adaptive

equipment/classroom adaptations to enhance gross motor movements including prone standers/standing frames; special chairs, leg braces, splints; and other positioning equipment. The last category is consultation with and training of staff in the following areas: handling, positioning, and safety/transfers.[19]

In the Moorhead, Minnesota, handbook,[20] the physical therapist's role is described as a supportive and supplemental service for students in special education whose motor abilities interfere with their educational performance. Responsibilities of the physical therapist include assessment, planning, goal development, and provision of intervention services so students can acquire functional skills needed to participate in and benefit from their education, and to give the student maximal functional independence. The physical therapist is primarily responsible for trunk range of motion and strengthening, mobility and locomotion (including assistive devices), movement in normal developmental sequence, balance and coordination, posture and positioning (including adaptive equipment), and neuromuscular facilitation.[20]

Physical therapists may have the administrative role of managing physical therapy services in the school setting. Martin[21] has outlined the planning, implementation, and evaluation of physical therapy services in a local school district or regional service district. The area of planning includes assessing the staff, assessing the needs of the school district, and assessing and clarifying the role of the educational team. Martin indicates that the manager must determine a realistic caseload that allows for provision of quality

care. She encourages the manager to consider preservices and inservices for staff to maintain competency and improve expertise. It is preferable for the manager to have knowledge of the different service delivery models and the school district's philosophy for special education in order to choose an appropriate service model. The manager should also be aware of factors affecting budget and equipment needs.[21]

Martin[21] also recommends that implementation of physical therapy service means the ability to provide a full spectrum of services. Implementation would include a therapy treatment/management plan to indicate type and frequency of treatment. Knowledge of federal, state, and individual district laws is necessary to determine eligibility for services and to help coordinate services within the community. The evaluation process covers program evaluation and staff evaluation. The program evaluation determines if quality and quantity of services are appropriate and effective. A written plan with goals and objectives should be established and then evaluated. The therapist evaluation tool should be available at the beginning of the job as well as job descriptions for each specific position. Martin[21] points out the importance of organization, communication, and collaboration with parents and other professionals when case managing the physical therapy client in the school setting.

Competencies and Specialization in Pediatric Physical Therapy

Several models have been developed to assist physical therapists in attaining and/or demonstrating competencies in pediatric physical therapy and

in gaining recognition for these competencies. Several institutions of higher education offer advanced degrees in areas of pediatric physical therapy. The APTA and its Section on Pediatrics have developed competency policy statements, continuing education programs, and a clinical specialization process. In 1976, the APTA House of Delegates approved the concept of specialization and established the Task Force on Clinical Specialization.[4] In 1978, the House of Delegates recognized four specialty areas, one of which was pediatrics. In 1979, the Board of Certification of Advanced Clinical Competencies (BCACC) was appointed by the APTA Board of Directors.[4] In 1981, the BCACC appointed four specialty councils including the Specialty Council on Pediatrics. In 1985, the "Competencies Necessary for Advanced Clinical Competence in Pediatric Physical Therapy Practice"[4] were approved by the BCACC. There are 16 competencies included in this document in the areas of prevention, physical examination, treatment design and modification, treatment implementation, consultation, coordination, research, educational services, and administration.[4]

The Pediatric Specialty Council has determined the following minimal criteria[22] for physical therapists to sit for the specialist certification examination. The applicant must hold a current license to practice physical therapy in the U.S.A. or any of its possessions or territories. The applicant must sit for, and pass, a written exam that tests advanced knowledge and clinical skills. The exam is given annually at the site of the APTA Combined Sections Meeting.

The applicant must have 6,240 hours (3 full-time years) of clinical practice in the specialty area of pediatric physical therapy completed within the past ten years. These hours must include 4,160 hours (2 full-time years) in direct patient care, 60% of which occurred within the last three years. The applicant must submit evidence of knowledge of competencies in the following four categories:[22] teaching, interpretation of scientific literature and the research process, administration, and consultation. The applicant must submit three character references.

The APTA offers a home study program titled Topics in Pediatrics from its In Touch series.[5] Information covered in the pediatrics series includes:

1. biomechanics of gait in children with CP
2. asthma
3. management of pediatric/adolescent sports injuries
4. balance disorders
5. growth and development in Down's syndrome
6. role of pediatric PT in infants exposed to cocaine in utero
7. developmental concepts for therapeutic intervention
8. post-surgical management after hamstring or gracilis release
9. high-risk neonate in the special care nursery
10. selective posterior rhizotomy
11. standardized tests in clinical practice
12. Public Law 99-457

All the topics are areas that may be encountered in PT practice in the school setting. A PT can earn continuing education credits with an optional self-administered exam. The current cost of this home-study program is $99 for APTA members and $139 for non-members. This is a cost-effective, convenient continuing education mechanism.[5]

In 1990 and 1991, the Section on Pediatrics of the APTA adopted a policy statement and competencies entitled "Competencies for Physical Therapists in Early Intervention." (Appendix A). The policy statement supports the participation of the physical therapist in early intervention programs, states the goal of the PT as a member of the intervention team, states premises upon which early intervention is based, and gives guidelines to assure quality service. The competencies listed should serve as guidelines for personnel standards, staff development, and quality assurance. Competent PTs should not be expected to have expertise in each area listed, but should strive for competency in each area.

One widely recognized advanced specialization in pediatric physical therapy is a certification course titled Bobath Eight-Week Course in the Treatment of Children with Cerebral Palsy.[23] This course is promoted by the Neuro-Developmental Treatment Association and teaches the approach to therapy originated by Dr. Karel and Physical Therapist (Mrs.) Berta Bobath. According to the Bobaths,[24] this is a hypothetical and speculative approach based on clinical experience treating children with cerebral palsy. This therapy

approach is currently known as neuro-developmental treatment. Course objectives include an understanding of:

1) the Bobath concept
2) the concept of inhibition and facilitation
3) the difference between normal and abnormal child development
4) the sensori-motor problems of the child with cerebral palsy
5) the importance of total management of the child

Objectives also include the ability to demonstrate proficiency in the assessment and treatment of children with cerebral palsy and the ability to train others in special handling techniques.

Another area of specialization involves sensory integration, an approach developed by A. Jean Ayers, Ph.D. Therapists can become certified in the administration and interpretation of the Sensory Integration and Praxis Tests (SIPT).[25] The SIPT is a standardized evaluation tool which measures the sensory integration processes that underlie learning and behavior. The SIPT helps identify specific problems associated with learning disabilities, behavioral problems, and functional disabilities. There are a series of courses that must be taken in order to become certified in administering and interpreting this exam.[25] The first course is a three-day course titled Sensory Integration Theory. After completing this course and a college level course in statistics, the therapist can apply to enter a three-step SIPT Certification Track. Step 1 includes a five-day course titled SIPT Administration followed by an individually

arranged observation of testing skills with a qualified observer. Step 2 is a three-day course titled SIPT Interpretation. Step 3 is taking a competency exam. All the courses and the exam are offered in key regional cities throughout the U.S. Each course costs between $300-500, and the cost of taking the exam is $75.00. There are specific time limitations for time between courses.[25]

Job Description

Each school district in North Dakota should develop its own job descriptions for personnel providing physical therapy services based on the needs of that district. According to the Bureau of Law and Business, Inc.,[26] a job description is defined as "a formalized statement of the duties, qualifications, and responsibilities of the job, based on information obtained through job analysis. Its purpose is to identify the job, define it within certain established limits, and describe its scope and content. It may include information on working conditions, tools and equipment used, and relationships with other jobs."[26(pp9-10)] The job description should differentiate the job from other jobs and set the job's outer limits. The five basic elements of a good job description are job identification, job summary or purpose, job duties and responsibilities, accountabilities, and job specifications.[26(p20)]

A job description may serve various purposes. Uses may include personnel administration (manpower planning, recruiting and screening, hiring and placement, orientation, training and development, and career ladders),

wage and salary administration (job evaluation, job classification, wage and salary surveys, pay structure, and performance appraisal), legal compliance, and collective bargaining.[26(pp11-14)]

After an assessment of needs, a complete job analysis and decision on use or purpose by the school district, a successful job description can be developed.

Physical Therapist Assistant

Qualifications

The North Dakota Physical Therapy Practice Act, Chapter 43-26,[6] states that an individual must be registered in order to practice as a physical therapist assistant in North Dakota. To be registered as a physical therapist assistant, a person must be at least 18 years old, be of good moral character, and have graduated from a program of physical therapist assistant training approved by the North Dakota State Examining Committee for Physical Therapists. An individual can be registered if they meet the above requirements and if they pass an examination. Registration must be renewed annually by paying a fee and providing evidence of continuing education.

Administrative Rules Title 61.5[7] defines a "program of physical therapist assistant training" as a curriculum approved by the American Medical Association or the American Physical Therapy Association. "Examination" is defined as the examination adopted by the American Physical Therapy Association or the Federation of State Boards of Physical Therapy.[7] "Physical

therapist assistant" means a person who assists, under the onsite direction of a registered physical therapist, in the practice of physical therapy and who performs such delegated procedures commensurate with the assistant's education and training.[7] Passing examination scores and registration requirements for U.S.-educated and foreign-educated applicants are the same as for the physical therapist applicant.[7]

Role of the Physical Therapist Assistant

The role of the physical therapist assistant (PTA) is dictated by the same state laws, national organization, and guidelines as the role of the physical therapist. The American Physical Therapy Association has adopted a policy statement titled "Definition and Utilization of the Physical Therapist Assistant."[1(p8.2)] In that document, the PTA is defined as "a health care worker who assists the physical therapist in the provision of physical therapy." PTAs are required to function under the direction and supervision of a physical therapist, performing physical therapy procedures and related tasks selected and delegated by the supervising physical therapist. This policy statement also lists the following physical therapy activities that shall not be performed by the PTA:[1(p8.2)] "interpretation of referrals; physical therapy initial evaluation and re-evaluation; identification, determination, or modification of plans of care (including goals and treatment programs); final discharge assessment/evaluation or establishment of the discharge plan; or therapeutic techniques beyond the skill and knowledge of the physical therapist assistant."

In Administrative Rules 61.5, which accompany the North Dakota Physical Therapy Practice Act, a physical therapist assistant is defined as "a person who assists, under the onsite direction of a registered physical therapist, in the practice of physical therapy, and who performs such delegated procedures commensurate with the assistant's education and training."[7(61.5-01-02-01)] In the Rules,[7] direct or onsite supervision means "personal direction or observation, and requires that the registered physical therapist be present on the premises at the time of treatment."[7(61.5-01-02-01)] Also in the Rules, direction means "the requirement that the physical therapist maintains continuous verbal and written contact with the physical therapist assistant, including onsite supervision and instruction adequate to ensure the safety and welfare of the patient."[7(61.5-01-02-01)]

The North Dakota State Examining Committee is currently considering revision of the supervision guidelines, so that in certain settings, including the school system, PTAs can work with intermittent supervision. North Dakota Century Code 43-26-01[6] currently states that one physical therapist may supervise no more than two physical therapist assistants. A revision of this guideline is also being considered.

In a job description and performance appraisal instrument for PTAs developed by the North Carolina Department of Public Instruction,[27] the major functions of the PTA include:

1) assisting the physical therapist in identifying students with motor deficits
2) administering treatment and management services based on the physical therapist's assessment and goals
3) assisting the physical therapist in management and maintenance of the physical therapy program
4) assisting the physical therapist in educating school personnel and parents
5) following ethical standards of the profession and seeking professional growth

The Oregon Health Science University manual[15] lists a comparison of the performance responsibilities for a physical therapist, a PTA, and a classroom aide. The major differences between the PT and the PTA are as follows. The PTA only assists in assessment and development of an IEP. The PTA implements but does not develop therapy programs to meet IEP goals. The PTA does not design motor programs but does teach others to implement motor programs prescribed by the PT. The PTA monitors but does not evaluate therapy programs. Similar performance responsibilities of the PT and PTA include collecting and recording data; communicating with teaching and support staff; ordering, using, and maintaining materials and equipment; monitoring and reporting student's progress; attending staff meetings; completing reports; and establishing professional growth goals.

The guidelines in Washington state note the following as the role description of the physical therapist assistant in the public school setting:[17(p96)] "The school PTA is a skilled, technical worker who performs physical therapy and related duties as assigned by the school PT. The work is carried out under the direction of the PT(s) to whom the PTA employee is responsible." The guidelines go on to describe specific responsibilities of the PTA in the two areas of student care and established physical therapy services. A table was developed to show which PT service needed a PT and those for which use of a PTA is permitted.[17(p96)] (Table 1) Also included in the guidelines is the amount of supervision of the PTA by the PT required by Washington State Physical Therapy Practice Act.

Table 1.--Roles of LPT and PTA

Physical Therapist (PT)	Physical Therapist Assistant (PTA) (under supervision of PT only)
Screening	
review files	initial screen of GM skills
student observation	
screening tool	
Assessment	
testing	
compile report	
interpret results	
Program Planning	
staffing	
teaming	
MDT & IEP meetings	
Treatment/Management	
direct therapy (hands on)	direct therapy
structured observation	(every 5th needs PT check)
adapting equipment	
Consultation	
with classroom staff (IEP team)	
with medical professionals & agencies	
with other professionals & parents	
Education	
parent training	
teacher/staff training	
Administrative	
scheduling	
recordkeeping	recordkeeping
order equipment	
arrange space	
supervision of PTA	
order equipment	maintain equipment
Evaluation	
case studies	
IEP review	

Physical Therapist Aide

Qualifications

Administrative Rule Title 61.5[7] defines a physical therapy aide as the category of personnel not otherwise defined who assist the physical therapy service as supportive personnel. Aides who work under the direct supervision of registered physical therapists do not have to be registered. If aides provide physical therapy services other than under the direct supervision of a registered physical therapist, they are in violation of North Dakota Century Code Chapter 43-26.[6] Direct or onsite supervision means the registered physical therapist must be present on the premises at the time the physical therapy service is provided.

Role of the Physical Therapy Aide

Individual state guidelines provide some idea of how the role of the physical therapy aide is defined. North Dakota Administrative Rules 61.5[7] contains the following definition. "Physical therapy aides, also known as health care aides, orderlies, etc. constitute the category of personnel not otherwise defined in this title who assist the physical therapy service as supportive personnel."[7(61.5-01-02-01)] If charging for the physical therapy service provided by the aide, the aide must work under the direct, onsite supervision of the physical therapist, which means that the physical therapist must be present on the premises at the time of treatment. In North Dakota in the school setting, if support personnel is titled a physical therapy aide, then the service they provide

must be given under the direct supervision of the physical therapist. If this support personnel is given another title, such as classroom or instructional aide, then they are able to carry out program recommendations given them by the physical therapist without the physical therapist directly supervising them.

In Iowa,[8] a physical therapy aide is an unlicensed supportive personnel and receives on-the-job training. Services provided by supportive personnel cannot be referred to as physical therapy unless the PT has physically participated in service each treatment day, and assumes responsibility for all delegated treatment. In Oregon,[15] aides working in the educational setting are called instructional aides. They do not provide physical therapy services, but they carry out motor activities and instructional programs under the direction of the classroom teacher. The teacher and physical therapist collaborate in determining appropriate motor activities. Other aide responsibilities described include providing information to the therapist about the student's functioning, collecting and recording data, managing student's behavior, and using and maintaining selected equipment.

In general, state guidelines on the role of the physical therapy aide emphasize the supervisory responsibility of the physical therapist, but are highly flexible as to the specific duties the physical therapy aide may undertake.

CHAPTER IV

SUMMARY AND CONCLUSIONS

While writing this independent study report, the author has been involved in three different situations in which these guidelines have had a definitive impact. The first situation involves proposed changes to the North Dakota Physical Therapy Practice Act.[6] One of the proposed changes in the Practice Act deals with supervision ratios and guidelines for physical therapist assistants. The proposed changes would eliminate a supervision ratio statement in the Practice Act. Instead, supervision ratios and guidelines for physical therapist assistants and other supportive personnel would be outlined in the Administrative Rules and Regulations[7] and would be "setting" specific. For example, the regulations for supervision of physical therapist assistants in the educational setting would be different than regulations for physical therapist assistants working in a medical acute care setting. The information on the role of the physical therapist assistant in the educational setting in this independent study report will be useful when writing changes in the Administrative Rules and Regulations relative to supervision of physical therapist assistants in this specific setting.

The second situation involves a Physical Therapy Task Force developed by the North Dakota Department of Public Instruction's Advisory Committee for

the Comprehensive System of Personnel Development to look at physical therapy as it applies to services for North Dakota children. According to a letter from Physical Therapy Task Force Chairperson Barry Chathams, Director of Oliver-Mercer Special Education, in October of 1992, one of the responsibilities of the Task Force is to make recommendations concerning needed policies/guidelines. (Appendix B) Barry Chathams and Jan Schimke from the Department of Public Instruction are the only members of the Task Force who are not physical therapists. At the first task force meeting, Barry and Jan were made aware of the fact that a group of physical therapists are in the process of developing guidelines for physical therapy practice in the educational setting in North Dakota. (Appendix C) At the second task force meeting, an update on these guidelines was presented by Erin Simunds, PT, who contacted each physical therapist writing a chapter of the guidelines. (Appendix D) The next task force meeting is scheduled for April of 1993 to allow time for completion of the proposed guidelines. Before the final guidelines are published, the proposed guidelines will be presented to task force members for their review and input.

The third situation was a January 1993 meeting in Grand Forks, North Dakota, of the North Dakota Interagency Coordinating Council Subcommittee on Personnel Development. According to a memorandum from Dr. Brent Askvig, Chairperson of the Personnel Development Subcommittee (Appendix E), the purpose of the meeting was to gather information on training needs of

physical therapists as outlined in P.L. 99-457,[3] and then to make recommendations to state agencies. Several physical therapists from northeast North Dakota who are involved in providing services to young children with disabilities, or providing training to students in the physical therapy program at the University of North Dakota, were invited to attend this meeting. Several written questions for consideration (Appendix F) that were addressed by this subcommittee related to information contained in this independent study report. This information included minimum standards for personnel in physical therapy practice, APTA specific recommendations regarding preparation of physical therapists to work with children ages birth through five [Competencies for Physical Therapists in Early Intervention (Appendix A)], and mechanisms for inservice training (competencies and specialization processes). This subcommittee was also informed about the guidelines being developed for physical therapy practice in the educational setting.

A meeting date has been set for March 27, 1993, in Devils Lake, North Dakota, for the eleven physical therapists who originally met in September, 1991, to consider developing guidelines for physical therapy practice in the public school setting. The purpose of the meeting will be to 1) review the independent study reports and other input written on topics relating to practice in the educational setting, 2) decide which portions of these reports to include in published guidelines for North Dakota, 3) develop a list of groups or individuals who might review the proposed guidelines before final publication, and

4) propose possible funding mechanisms for publishing the guidelines.

Physical therapy, while considered a support or ancillary service under P.L. 94-142, is truly a critical "related" service. As the "trunk" of the rehabilitation tree, the essentiality of physical therapy, and the personnel in this field, cannot be over-emphasized. Cost of service provision, and quality of service, are ongoing concerns. It was the intent of this independent study report to clarify the appropriate use of personnel, and thus to ultimately maximize quality and access while minimizing cost. Use of properly trained personnel in the proper role will do just that.

APPENDIX A

Competencies for Physical Therapists in Early Intervention

APTA Task Force on Early Intervention, Section on Pediatrics

The Section on Pediatrics of the American Physical Therapy Association supports the active participation by physical therapists trained in pediatrics in providing early intervention services to infants, toddlers, preschoolers, and their families. All children are entitled to the opportunity to develop to their maximal potential regardless of race, creed, economic status, or disability. Federal legislation PL 99-457, the Education of the Handicapped Act Amendments of 1986, supports the right to early intervention services of all infants, toddlers, and preschoolers with a disability or those at risk of having substantial developmental delays. Specifically included are physical development and physical therapy services delivered by a qualified physical therapist.

Early intervention has its foundation on the following premises: (a) the first years of life represent a period of rapid growth and development that are foundational for later development; (b) infants have the ability to actively interact and form attachments; (c) infants have the capacity to learn; (d) parents have the primary role in nurturing and in providing early learning experiences; (e) parents of children with special needs may require assistance or instruction to effectively care for their child; (f) developmental outcome is determined by the interaction between biological insult and environmental factors; and (g) structured programming can improve the abilities of infants and children and their families. In addition, physical therapy early intervention is based on the following assumptions: (a) nervous system plasticity exists; (b) young children are sensorimotor learners; (c) acquisition of motor skills is a major component of early development; (d) intervention must be started early to provide optimal outcome and prevent the development of secondary disability; and (e) family-centered services provide for maximum intervention.

The Section on Pediatrics believes that the physical therapist plays a vital role in early intervention programs; this has historically been true, and PL 99-457 supports the continuation of that role. The goal of the physical therapist, as a member of the early intervention team, is to specifically encourage sensorimotor function by enhancing motor and perceptual development, musculoskeletal status, neurobehavioral organization, cardiopulmonary status, and effective environmental adaptation and to provide support to families in the care of their child with special needs.

To assure quality service in early intervention programs, the following guidelines for use of physical therapy personnel are recommended: (a) a qualified, licensed physical therapist must supervise all physical therapy-related services and (b) new graduates or physical therapy generalists must work under the preceptorship of a therapist experienced in pediatrics until basic pediatric competencies are achieved. Physical therapy education programs, advanced master's degree pediatric specialty programs, and inservice and continuing education courses need to provide relevant educational opportuni-

(Continued on next page)

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'EDIATRIC PHYSICAL THERAPY

Address correspondence to: Susan K. Effgen, PhD, PT, Director, Program in Pediatric Physical Therapy, Hahnemann University, MS 502, Broad and Vine Streets, Philadelphia, PA 19102.

'he members of the Task Force on Early Intervention are: Susan K. Effgen, PhD, PT (Chair), Kristie Bjornson, MS, PT, Lisa Chiarello, PT, .in Sinzer, MS, PT, and Wendy Phillips, MS, PT.

(Continued from previous page)
ties to prepare the therapist for the diverse responsibilities of family-focused, interdisciplinary early intervention. Therapists must be willing to acquire advanced knowledge and skills in pediatric physical therapy and expand their knowledge in other areas in order to be effective team members, case managers, and family advocates. Physical therapists in early intervention must be dedicated to collecting data to establish the most effective methods of service delivery and intervention approaches.

The competencies that follow are meant to serve as a guideline for personnel standards, staff development, and quality assurance. Competent physical therapists will probably not have expertise in every area but should strive to achieve competency in each area.

This policy statement was adopted by the Section on Pediatrics in January 1990. The competencies were adopted in February 1991.

1.0 The physical therapist can design and implement programs to promote wellness and to screen for and prevent disabilities in infants and toddlers.

1.1 Design and implement a screening program to identify infants at risk for movement disorders, developmental delay, and sensory, orthopedic, neurologic, or cardiopulmonary dysfunctions, and make appropriate referrals.

1.2 Identify and discuss the significance of early signs of potential atypical development.

1.3 Select, administer, and interpret to parents and professionals a variety of screening instruments and standardized measurement tools.

1.4 Access and apply knowledge of a standard baseline of wellness for each age and developmental area.

1.5 Recognize the effect of maternal health and nutrition on fetal development, demonstrate knowledge of risk factors affecting growth and development, and promote well being.

1.6 Demonstrate knowledge of genetic, cultural, and historical differences in standards for growth and development.

1.7 Identify established biological and environmental factors affecting development.

1.8 Demonstrate knowledge of environmental hazards and accident prevention, and provide anticipatory guidance.

1.9 Promote infant safety and wellness using knowledge of home and toy safety measures, cardiopulmonary resuscitation, and recognition of child abuse.

1.10 Disseminate information about the availability of early intervention and physical therapy services, criteria for eligibility, and methods of referral.

1.11 Collect and use data from multiple sources for comprehensive child-find systems.

2.0 The physical therapist can conduct, write, and interpret to parents and professionals a comprehensive assessment of the infant and toddler (0–5 years).

2.1 Demonstrate knowledge of the normal sequence of development, the interrelationship among developmental areas, the range of normal variations of development, and the difference between delayed and atypical sensorimotor development.

2.2 Demonstrate the ability to selectively gather, interpret, and report from the available medical/developmental records.

2.3 Critically identify, compare, select, and administer valid, reliable, and nondiscriminatory assessment instruments appropriate to age, population, disability, and setting.

2.4 Demonstrate knowledge of appropriate selection and application of assessment tools for screening and identification, comprehensive sensorimotor diagnostic evaluation, individual program planning, monitoring of child progress, and documenting program impact.

2.5 Demonstrate knowledge of validity, reliability, test construction, and theoretical bases of assessment instruments.

2.6 Administer and interpret the results of a wide variety of formal and informal assessment instruments, techniques, and procedures in naturalistic and structured settings.

2.7 Demonstrate knowledge and skill in assessment of: (a) functional ability, including activities of daily living and gross motor, fine motor, perceptual motor, and oral motor skills; (b) musculoskeletal status, including strength, joint range of motion, joint integrity, and posture; (c) neuromotor assessment, including reflex development, postural responses, and analysis of movement patterns; (d) sensory status, including tactile, proprioceptive, and vestibular; and (e) cardiopulmonary status.

2.8 Individualize the assessment and testing environments to child, team, and family needs.

2.9 Involve the family in the assessment process and assess the effect of the process on the child and family.

2.10 Write an evaluation summarizing the results of formal, informal, and observational assessment, with appropriate interpretation of results for differential diagnosis and clinical decision making.

2.11 Accurately interpret assessment findings to the family and other team members and integrate their input in formulating recommendations.

2.12 Identify, select, evaluate, and recommend therapeutic equipment, including positioning aids, mobility aids, adaptive toys, aids for activities of daily living, and orthotics.

2.13 Identify, evaluate, and make recommendations and designs for accessible environments to promote independence.

3.0 The physical therapist can identify, write, assess, and evaluate, consistent with the family's needs and resources, appropriate measurable long- and short-term treatment objectives for the infant and toddler who is at risk for or who has a disability.

3.1 Use assessment information, in conjunction with the family's goals, to develop objectives that are clinically indicated and functionally appropriate and measurable.

3.2 Prioritize needs identified during assessment according to environmental demands, future environmental demands, resources, developmental level, past history, and family preference and goals.
3.3 Write specific, measurable long- and short-term objectives incorporating the recommendations and priorities of the family and other team members.
3.4 Integrate objectives with those of the parents and other team members as part of the team process.
3.5 Select and use objective means of monitoring progress toward meeting objectives to evaluate the effectiveness of physical therapy.
3.6 Revise objectives in consultation with the family and other team members.
3.7 Evaluate progress and expected time frames in meeting objectives.

4.0 The physical therapist can assist in multidisciplinary/interdisciplinary/transdisciplinary assessment, program development, and implementation of an Individualized Family Service Plan (IFSP) and can serve as the case manager/service coordinator.

4.1 Function as a team leader or member in a multidisciplinary, interdisciplinary, or transdisciplinary assessment.
4.2 Conduct a family interview to assist family members in identifying their strengths, needs, and priorities.
4.3 Develop, in collaboration with the family and other team members, an IFSP to meet the needs of the family and the child.
4.4 Demonstrate sound professional decision making when determining frequency, intensity, location, and method of service delivery.
4.5 Demonstrate effective writing skills by producing thorough, appropriate, and useful documentation.
4.6 Oversee implementation of the IFSP to ensure quality of care, and demonstrate the ability to serve as case manager/service coordinator.
4.7 Provide ongoing program evaluation and family needs assessment, and make recommendations to revise the IFSP as indicated.
4.8 Demonstrate knowledge of community resources and coordinate interagency activities.
4.9 Coordinate transition planning, implementation of the transition plan, and follow-up activities.

5.0 The physical therapist can design, implement, and evaluate a physical therapy program for infants and toddlers who are at risk for or who have a disability and for their families.

5.1 Demonstrate knowledge of developmentally appropriate physical therapy intervention strategies and therapeutic procedures for infants and toddlers who are at risk for or who have a disability and for their families.
5.2 Demonstrate an understanding of the theoretical basis(es) for therapeutic interventions for infants and toddlers who are at risk for or who have a disability and for their families.
5.3 Demonstrate skill in selecting, individualizing, and implementing developmentally appropriate physical therapy intervention strategies, adaptive equipment, and therapeutic procedures for infants and toddlers who are at risk for or who have a disability and for their families.
5.4 Demonstrate skill in modifying developmentally appropriate physical therapy intervention strategies, adaptive equipment, and therapeutic procedures in accordance with changes in the infant's functional level, medical status, or family needs.
5.5 Demonstrate the ability to evaluate and document the effectiveness of physical therapy intervention strategies and therapeutic procedures in structured activities and natural settings using reliable measures.
5.6 Integrate physical therapy intervention strategies into the home and center-based educational programs through recommendations for daily functioning and such child care activities as feeding, bathing, dressing, and playing.
5.7 Demonstrate skill in functioning as a primary service provider and transdisciplinary team member to implement an integrated intervention program.
5.8 Demonstrate an understanding of the basic principles of behavior management to facilitate appropriate motor and psychosocial learning within the family unit and in the therapy environment.
5.9 Demonstrate knowledge and skill in selecting and applying different service delivery methods and models of early intervention.
5.10 Discuss basic learning theories and relate them to physical therapy early intervention programs.

6.0 The physical therapist can discuss the implications of local, state, and federal laws, rules and regulations affecting early intervention and the practice of physical therapy in early intervention.

6.1 Identify and discuss the global goals and responsibilities of physical therapy in early intervention.
6.2 Demonstrate knowledge of PL 94-142 and PL 99-457 and their impact on the delivery of services to infants and toddlers who are at risk for or who have a disability and on their families.
6.3 Discuss state and local regulations affecting the delivery of early intervention services to infants, toddlers, and their families.
6.4 Demonstrate professional behavior through knowledge of the ethical and legal responsibilities of a licensed physical therapist.
6.5 Identify and use information sources for federal, state, and local legislation and regulation changes.
6.6 Demonstrate knowledge of the competencies for physical therapy services in early intervention as defined by professional organizations and state regulations.

7.0 The physical therapist can demonstrate knowledge of the importance of family systems theory and is able to provide family-focused services.

7.1 Demonstrate knowledge of family systems theory and its application to early intervention.
7.2 Discuss the impact of a child with special needs upon a family unit.
7.3 Discuss, design, and implement basic strategies to support the family unit, including the marital dyad, parental competence, parent-child relationships, and sibling subsystems, and demonstrate skill in empowering the family.
7.4 Support the parents' primary roles as mother and father to the child.
7.5 Advocate the right of parents to be decision makers in the early intervention process, and provide them with the information and options needed for informed decisions.
7.6 Identify and discuss cultural, socioeconomic, ethical, historical, and personal values and factors affecting a child's and family's development and early intervention program.
7.7 Demonstrate communication skills needed to estab-

lish a collaborative relationship with the child and the family.

7.8 Acknowledge the value of the family as the most significant member of the team and collaborate with family members to identify their priorities, strengths, needs, and goals.

7.9 Develop an individualized family-focused intervention program to enhance the growth and development of the child through a partnership with the family.

7.10 Assist the family in identifying and developing internal and external resources, a social support network, and advocacy skills.

7.11 Respect the family and demonstrate personal characteristics that enhance successful interaction with team members, the child, and the family.

8.0 The physical therapist can function as a consultant, supervisor, educator, community liaison, and multidisciplinary/interdisciplinary/transdisciplinary team member.

8.1 Discuss and interpret assessment findings with early intervention team members and family.

8.2 Demonstrate understanding of the role of other early intervention team members, including the family, special educator, social worker, psychologist, occupational therapist, speech and language pathologist, audiologist, nurse, nutritionist, and physician.

8.3 Identify the administrative and interpersonal factors that influence the effectiveness of a consultant.

8.4 Function as a consultant by providing technical assistance to other early intervention team members, community agencies, and medical facilities.

8.5 Demonstrate the ability to supervise supportive personnel and professional students in early intervention settings.

8.6 Demonstrate skill in formal and informal teaching of students, families, paraprofessionals, and professionals concerning physical therapy in early intervention.

8.7 Recognize the necessity for, and demonstrate the ability to establish, a physical therapy student clinical affiliation in an early intervention program.

8.8 Demonstrate the ability to monitor the implementation of physical therapy recommendations by other team members.

8.9 Demonstrate the ability to refer and coordinate services among other professionals, community agencies, day care programs, and the family.

8.10 Conduct public awareness activities to promote support and acceptance of early intervention by the community.

8.11 Demonstrate the knowledge and ability to function as a multidisciplinary, interdisciplinary, and transdisciplinary team member.

8.12 Demonstrate the ability to relinquish a domain-specific role during the transdisciplinary process.

8.13 Demonstrate effective and appropriate interpersonal communication skills.

8.14 Demonstrate knowledge of the dynamics of group interactions and determine strategies for team development and management.

9.0 The physical therapist can demonstrate knowledge of current research related to physical therapy in early intervention and closely related disciplines.

9.1 Demonstrate knowledge of current research relating to infant development, medical care, and developmental intervention for infants and toddlers who are at risk or who have a disability and to their families.

9.2 Demonstrate the ability to conduct a literature review using such reference materials as *Index Medicus, Psychological Review,* or data base sources.

9.3 Apply knowledge of research to the selection of physical therapy intervention strategies, service delivery systems, and therapeutic procedures in early intervention.

9.4 Read and integrate relevant research, relate findings to issues in clinical practice, and alter intervention approaches based on empirical findings.

9.5 Seek assistance from experienced researchers in interpreting published research and developing clinical research projects.

9.6 Identify topics in early intervention in which research efforts are needed.

9.7 Use objective criteria for evaluation and expand clinical treatment cases into single-subject studies.

9.8 Participate in program evaluation activities with the appropriate supervision.

10.0 The physical therapist can plan, implement, and evaluate the administrative components of physical therapy in early intervention.

10.1 Identify the philosophy, goals, structure and function, and administrative needs of the early intervention program and physical therapy.

10.2 Identify both the overall and the unique functions of physical therapy and other services within the early intervention setting.

10.3 Demonstrate the ability to apply knowledge of other disciplines' roles and functions for program planning and policy formation.

10.4 Appraise education, health, and/or social trends that have current or potential implications for early intervention programs and physical therapy.

10.5 Direct physical therapy program operations and delegate appropriate responsibilities.

10.6 Identify, develop, implement, and monitor physical therapy policies, procedures, and standards of care.

10.7 Develop and implement criteria and procedures for job descriptions, recruitment, staff selection, supervision, and performance appraisals.

10.8 Establish appropriate and manageable caseloads.

10.9 Demonstrate the ability to assist and support the professional development of early intervention personnel.

10.10 Demonstrate leadership abilities in promoting effective team processes.

10.11 Identify and develop appropriate referral mechanisms.

10.12 Identify intramural and extramural funding sources and demonstrate the ability to plan and manage a budget.

10.13 Idenitfy and use appropriate community, state, and national resources.

10.14 Develop procedures for documenting services in accordance with the American Physical Therapy Association Code of Ethics, funding agency policies, and federal, state, and local regulations.

10.15 Plan and implement quality assurance programs and program evaluations for early intervention services.

10.16 Develop long-range planning in order to improve quality of service and meet community needs.

10.17 Develop appropriate public relations activities and skills in interagency collaboration.

APPENDIX B

Mercer
Oliver
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Oliver - Mercer Special Education
Box E, Hazen, North Dakota 58545
(701) 748-6383

October 21, 1992

Erin Simmunds
Department of Physical Therapy
School of Medicine
501 North Columbia Road
Grand Forks, ND 58203

Dear Erin,

The Department of Public Instruction's Advisory Committee for the Comprehensive System of Personnel Development has asked me to chair a Task Force to look at Physical Therapy as it applies to services for children in North Dakota.

This Task Force's responsibility is as follows:

The charge for the Task Force on Physical Therapy is to discuss, review the issues, and prepare written recommendations on what standards and policies are needed to assure that physical therapy services are conducted by qualified staff who have appropriate training to work with students, family members, educators, and other agency service providers in developing programs designed to meet the unique needs of students with disabilities. Specifically, it is the responsibility of the Task Force to.....

(a) review the current status of Physical Therapy services in schools across the state;
(b) review staffing and service needs;
(c) make recommendations regarding licensure requirements for Physical Therapy personnel working in school settings;
(d) make recommendations regarding training requirements of other disciplinary personnel that work in collaboration with PT programs (e.g. special education teachers, occupational therapists, school psychologists, administrators, etc);
(e) review resources and needs for delivery of preservice and inservice training;
(f) make recommendations on how the immediate and long term training needs of personnel can be met;
(g) make recommendations concerning other needed policies/guidelines.

Therefore, would you consider becoming a member of this Task Force. I anticipate meeting approximately three times (December, January, February). The meeting would be held in Minot which should be centrally located for the majority of the members. The meetings would begin at 10:30 CST and conclude about 3:00 CST. Meals and mileage would be paid at the state rate through a reimbursement voucher by the State Department. Overnight lodging is an option if required.

The initial meeting is set for Tuesday, December 1, 1992. The specific location will be set once the committee members is formed. Please return by November 13, 1992 the enclosed sheet in order that I can proceed with filling the membership for our Physical Therapy Task Force.

Sincerely,

Barry Chathams

Barry Chathams, Director

BC/saa
enc.

APPENDIX C

PHYSICAL THERAPY TASK FORCE
Board of Education Building, Minot ND
December 1, 1992

Members Present: Barry Chathams, Chairman
Ron Torkelson, Marvin Stitt, Judy Bahe, Erin Simunds, Anne Putbrese, Jan Schimke

Not Present: Jodi Roller, Jann Belanus, Robert Benson

The charge for the Task Force on Physical Therapy was reviewed by Barry Chathams.

(a) Review of current status of Physical Therapy in schools
-Locations are rural in some areas so it is hard to access services.
-How are services defined? Medical or Educational?

(b) Review of staffing and service needs
-Do we use aides to deliver services?
-What is the method of delivery of PT services in schools?

(c) Recommendations regarding licensure
-Review North Dakota Physical Therapy Act.
-Anne Putbrese is on the PT State Licensure Board and they are looking at the Practice Act to see if any changes should be made in the Act, especially in the Physical Therapy Assistance (PTA) supervision area.

(d) Make recommendations regarding training
-Physical Therapy Program at UND
-New Physical Therapy Assistant (PTA) program at UND-Williston
-Erin Simunds, UND, states that more information is needed regarding physical therapy in the educational settings.
-Maybe there needs to be an overlap in the university training programs for special education teachers, occupational therapy and physical therapy.

(e) Review resources and needs for delivery of preservice and inservice training
-Need more interdisciplinary inservice
-Using the IVN (Interactive Video Network) is effective because most people only have a one hour drive to attend class.
-"Update on Special Education Law" was taught on IVN network in August. The course was organized through UND and the Special Education Division of the Department of Public Instruction. The link through the University system made the cost for the course much more reasonable.

-Erin Simunds is looking at a grant for more inservice monies.
-Check on collaborative arrangements with the special education training programs at UND (Dr. John Hoover)

(f) Make recommendations on how the immediate and long term training needs of personnel can be met
-Look into the Physical Therapy Assistant program at UND-Williston. Will there be a possibility to use PTA's in the school systems without direct supervision from a PT?
-Emphasize pediatrics in the training programs so more Physical Therapists will be trained in an educational model.

(g) Make recommendations concerning other needed policies/ guidelines.
-North Dakota does not have written guidelines for the role of physical therapists in the educational settings.
-Graduate students in the UND Physical Therapy master's degree program are writing North Dakota Educational Guidelines. Judy Bahe will update the committee regarding the guidelines.
-Service models vary from one special education unit to another unit so this creates a concern on consistent and appropriate delivery of services in North Dakota. Statewide policies and guidelines would be beneficial to the special education units.
-Check terminology used in IEPs. Is the proper language used to describe the current service delivery models?
*Define Service Provider
*Define role of PT Aide
*Define Direct Service
*Define Consultation
*Define type of program in school setting (School program, Exercise program, Home program)

Barry Chathams conducted a 10 question mailout survey with special education unit directors as of November 13, 1992. He shared the results with the PT Task Force members.

Peggy Mohr has a project through DPI and may have more needs assessment information that the Task Force can access.

Erin Simunds and Anne Putbrese will also send Barry some additional questions to ask the special education unit directors.

NEXT MEETING DATE
January 26, 1993 - 10:30 to 3:00
Board Room
Minot Public Schools Board of Education Building
215 2nd St SE
Minot, ND

APPENDIX D

PHYSICAL THERAPY TASK FORCE

Board Room
Minot Public Schools
215 2nd St. SE
Minot, ND

AGENDA

JANUARY 26, 1993
10:30 - 3:00

10:30 a.m.	**Review minutes from December 1, 1992 meeting**
10:45 a.m.	**Report on proposed changes in the Physical Therapy Practice Act** **-Anne Putbrese**
11:30 a.m.	**Overview of the Physical Therapist Assistant (PTA) program at UND-Williston** **-Robert Benson**
12:00 noon	**Lunch**
1:00 p.m.	**Information gathered from survey questions put together by Erin Simunds and Anne Putbrese** **-Barry Chathams**
1:30 p.m.	**Update on guidelines for the role of the Physical Therapist in the educational setting** **-Erin Simunds**
2:00 p.m.	**Review guidelines from other states on educational services provided by Physical Therapists** **-Barry Chathams**
2:15 p.m.	**Plan of action for next meeting**

APPENDIX E

NORTH DAKOTA INTERAGENCY COORDINATING COUNCIL

FOR CHILDREN WITH DISABILITIES BIRTH THROUGH FIVE

TO: Personnel Development Professionals

FROM: Dr. Brent Askvig
Chairperson Personnel Development Subcommittee

RE: Personnel Development/Training for people working with children with disabilities ages birth through five and their families

Meeting Date: January 21-22, 1993
Place: North Dakota School For The Blind
Grand Forks, ND
Time: January 21, 1993
Physical Therapists 10:30 - 11:45 a.m.
Psychologists 1:00 - 2:15 p.m.
Occupational Therapists 2:30 - 4:15 p.m.
January 22, 1993
Pediatricians 8:30 - 10:00 a.m.
Orientation & Mobility 10:30 - 11:45 a.m.

The purpose of the North Dakota Interagency Coordinating Council Subcommittee on Personnel Development is to gather information on training needs of all disciplines outlined in P.L. 99-457 and make recommendations through the North Dakota Interagency Coordinating Council to state agencies.

You have been invited to give your viewpoints on your discipline's role and involvement in early childhood services. We are particularly interested in gaining an understanding of your discipline's licensure/certification, preservice training and inservice training systems.

The enclosed sheet provides a listing of several specific issues relating to your discipline.

We will be meeting at the North Dakota School for the Blind in Grand Forks on January 21 & 22, 1993. On January 21 the physical therapy group will meet from 10:30 p.m. - 11:45 p.m., the psychology group from 1:00 p.m. - 2:15 p.m. and the occupational therapy group from 2:30 p.m. - 4:15 p.m. On January 22 the pediatric group will meet from 8:30 a.m. - 10:00 and the orientation and mobility group from 10:30 -11:45 a.m.

We appreciate your willingness to spend time with this subcommittee. If you have any questions, feel free to call me at 857-3050.

Enclosures
Questions for consideration
DEC competency listing

People Attending — weather permitting:
Erin Simunds
Peg Mohr.
Jann Belanus - DL ID.
Amy Elbert - School for Blind
Marcia Weke - GF Public School SX.
Ann Pubtrede - MCRH. CETP

Represents a continuum of service delivery — all

APPENDIX F

QUESTIONS FOR CONSIDERATION
PERSONNEL DEVELOPMENT

1. What are the minimum standards for personnel within your discipline?

2. Within those standards are there any special components specific to young children with disabilities birth through five?

3. Where are the preservice training programs in North Dakota for your discipline?

4. Within those preservice training programs, what are the special considerations given to young children with disabilities (e.g. course work, internships, clinical experience, student teaching)?

5. Does your state or national professional organization have specific recommendations regarding preservice preparation for personnel to work with young children with disabilities birth through five?

6. What is your opinion of how North Dakota is meeting those preservice recommendations for personnel working with young children with disabilities birth through five?

7. What mechanisms for inservice training does your state or local professional organization utilize? (State annual conference, local workshops, other inservice training programs)

8. Do those inservice training programs typically address service provision for birth through five children with disabilities and their families? If so, what are the topics or issues discussed?

9. What are your perceived needs for training personnel to work with children with disabilities birth through five?

10. What are your suggestions for linking with other disciplines, agencies, programs to meet these training needs?

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